STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

D. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and include the frequency and duration for services.

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Rehabilitation care is to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

R. Utilization Review of Case Management for Recipients of Auxiliary Grants.

A. Criteria of Need for Case Management Services. It shall be the responsibility of the assessor who identifies the individual's need for residential or assisted living in an adult care residence to assess the need for case management services. The case manager shall, at a minimum, update the assessment and make any necessary referrals for service as part of the case management annual visit. Case management services may be initiated at any time during the year that a need is identified.

B. Coverage Limits. DMAS shall reimburse for one case management visit per year for every individual who receives an Auxiliary Grant. For individuals meeting the following ongoing case management criteria, DMAS shall reimburse for one case management visit per calendar quarter:

1. The individual needs the coordination of multiple services and the individual does not currently have support available that is willing to assist in the coordination of and access to services, and a referral to a formal or informal support system will not meet the individual's needs, or

2. The individual has an identified need in his physical environment, support system, financial resources, emotional or physical health which must be addressed to ensure the individual's health and welfare and other formal or informal supports have either been unsuccessful in their efforts or are unavailable to assist the individual in resolving the need.

C. Documentation requirements.

1. The update to the assessment shall be required annually regardless of whether the individual is authorized for ongoing case management.

2. A Care Plan and documentation of contacts must be maintained by the case manager for persons authorized for ongoing case management.

a. The Care Plan must be a standardized written description of the needs which cannot be met by the adult care residence and the resident-specific goals, objectives and time frames for completion. This Care Plan must be updated annually at the time of reassessment, including signature by both the resident and case manager.

b. The case manager shall provide ongoing monitoring and arrangement of services according to the care plan and must maintain documentation recording all contacts made with or on behalf of the resident.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

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12 VAC 30-60-170.
Utilization review of foster care case management services (FC).

A. Service description and provider qualifications. FC case management is a community based program where treatment services are designed to address the special needs of children. FC case management focuses on a continuity of services, is goal directed, results oriented, and emphasizes permanency planning for the child in care but shall not include room and board. Children, whose conditions meet the medical necessity criteria in this section, will be eligible for Medicaid payment for FC case management. FC case management will serve children under age 21 in treatment foster care who are seriously emotionally disturbed (SED) or children with behavioral disorders who in the absence of such programs, would be at risk for placement into more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs or group homes. Child placing agencies licensed or certified by the Virginia Department of Social Services and which meet the provider qualifications for treatment foster care set forth in these regulations shall provide these services.

B. Utilization control. Assessments; qualified assessors preauthorization and medical necessity criteria.

1. Assessment. Each child referred for FC case management must be assessed by a Family Assessment and Planning Team (FAPT) under the Comprehensive Services Act (*Code* §2.1-754 et seq.). The team must:

   a. Assess the child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

   b. Assess the potential for reunification of the recipient's family;

   c. Set treatment objectives; and

   d. Prescribe therapeutic modalities to achieve the plan's objectives.

2. Qualified assessors. A Family Assessment and Planning Team (FAPT) as authorized by the *Code of Virginia* §2.1-754.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

3. Preauthorization. Preauthorization shall be required for Medicaid payment of FC case management services for each admission and will be conducted by DMAS or its utilization management contractor. Failure to obtain authorization of Medicaid reimbursement for this service prior to onset of services may result in denial of payments or recovery of expenditures.

4. Medical Necessity Criteria. The child being considered for FC case management must have a documented moderate to severe impairment and moderate to severe risk factors as recorded on a state designated uniform assessment instrument. The child's condition must meet one of the three levels described below.

   a. Level I. The child must display moderate impairment with one or more of the following moderate risk factors, as documented on the state designated uniform assessment instrument:

      (1) Needs intensive supervision to prevent harmful consequences;

      (2) Moderate/frequent disruptive or noncompliant behaviors in home setting which increase the risk to self or others;

      (3) Needs assistance of trained professionals as caregivers.

   b. Level II. The child must display a significant impairment or problems with authority, impulsivity, and caregiver issues, as documented on the state designated uniform assessment instrument. For example, the child must:

      (1) Be unable to handle the emotional demands of family living;

      (2) Need 24-hour immediate response to crisis behaviors; or

      (3) Have severe disruptive peer and authority interactions that increase risk and impede growth.

   c. Level III. The child must display a significant impairment with severe risk factors as documented on the state designated uniform assessment instrument. Child must demonstrate risk behaviors that create significant risk of harm to self or others.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

5. FC Case Management Admission Documentation Required. Before Medicaid preauthorization will be granted, the referring entity must submit to DMAS the following documentation. The documentation will be evaluated by DMAS or its designee to determine whether the child's condition meets the Department's medical necessity criteria.

   a. A completed state designated uniform assessment instrument together; AND

   b. All of the following documentation:

      (1) Diagnosis, (Diagnostic Statistical Manual, Fourth Revision (DSM IV), including Axis I (Clinical Disorders); Axis II (Personality Disorders/Mental Retardation); Axis III (General Medical Conditions); Axis IV (Psychosocial and Environmental Problems); and Axis V (Global Assessment of Functioning;

      (2) Description of the child's immediate behavior prior to admission;

      (3) Description of alternative placements tried or explored;

      (4) The child's functional level;

      (5) Clinical stability; and

      (6) The level of family support available. AND

   c. Written documentation that the Community Planning and Management Team (CPMT) has approved the admission to treatment foster care;

6. Penalty for failure to obtain preauthorization or to prepare and maintain the previously described documentation. The failure to obtain authorization of Medicaid reimbursement for this service or to develop and maintain the documentation enumerated above prior to the onset of services may result in denial of payments or recovery of expenditures.